Contents

Introduction 2

When You Or Your Dependents Become Entitled to Medicare 2

Your Plan Choices 4

The SHP's Standard Plan and Medicare 5

The Medicare Supplemental Plan and Medicare 9

HMO Plans and Medicare 15

Comparison of Health Plan Benefits for Retirees and Dependents Entitled to Medicare 18

2004 Monthly Premiums 22

- Regular Retiree (State-Funded Benefits) Monthly Premiums 22
- 2004 Retiree Full Cost (Non-Funded) Monthly Premiums 23
- 2004 Survivor Monthly Premiums 24

Who to Contact for More Information 25

Glossary 27

Introduction

This book is designed to provide you with helpful information for making insurance coverage decisions when you become entitled to Medicare. Please review this book and discuss your benefit choices with family members prior to making decisions. More detailed information regarding the various benefits programs may be found in the *Insurance Benefits Guide*, which is available from your employer or from the Employee Insurance Program (EIP). Please contact EIP if you have any questions or need additional information. You may visit our Web site at www.eip.sc.gov or call us at 803-734-0678 (toll-free at 888-260-9430).

The summary of benefits in this handbook does not represent an employee/employer contract. Program provisions are subject to change. This information is designed to assist you in making insurance coverage decisions. Please consult your *Insurance Benefits Guide* and information and literature from the various HMOs offered in your service area. The *Plan of Benefits Document* and the state basic dental fee schedule are available from your benefits office or the Employee Insurance Program for specific contractual questions.

When You Or Your Dependents Become Entitled to Medicare

About Medicare

Medicare has two parts—*Part A* and *Part B*. Part A is your hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while working. Part A helps cover your inpatient care in hospitals, critical access hospitals in rural areas and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions to be eligible for Part A. Contact Medicare for additional information.

Medicare Part B is your medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services and outpatient hospital care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists and home health care. Part B pays for these covered services and supplies when they are medically necessary.

It is important to be enrolled in Part B if you are covered as a retiree or a dependent of a retiree because the State Health Plan will be the secondary payer and will coordinate benefits as if Medicare Part B has paid.

Medicare guarantees you coverage, regardless of health, if you are eligible. There are no pre-existing conditions, limitations or exclusions.

The Medicare + Choice program was created by the *Balanced Budget Act* of 1997. Individuals may now choose from a number of new health plan options in addition to Part A and Part B under the original Medicare program. Types of plans available, depending upon availability in your area, may

include health maintenance organizations (HMOs), HMOs with Point of Service options, preferred provider organizations, provider sponsored organizations, etc. You must have Medicare Part A and Part B to join a Medicare + Choice plan. These additional plan options are not addressed in this publication. Call Medicare or visit the Medicare Web site (see below) for additional information. To find out more about Medicare:

- Visit the Medicare Web site at www.medicare.gov;
- Call 800-MEDICARE (800-633-4227, 877-486-2048 TTY).

At Age 65

You should be notified of Medicare entitlement by the Social Security Administration three months in advance of reaching age 65 or at the time of entitlement due to disability. If not, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B start automatically. If you're not receiving Social Security, you should sign up for Medicare close to your 65th birthday, even if you aren't ready to retire.

If You Are an Active Employee

If you're actively working and/or covered under a state health plan for active employees, you do not need to sign up for Part B because your insurance as an active employee remains primary while you are actively working. However, if you are planning to retire within three months of age 65, you should contact Social Security concerning your enrollment options. Keep in mind that when you subsequently retire you should sign up for Part B within 31 days of retirement as Medicare becomes your primary coverage in retirement.

If You Are a Retiree

If you are entitled to Medicare due to reaching age 65, EIP will notify you three months in advance of your 65th birthday so you may decide whether to change to the Medicare Supplemental plan or retain the Standard plan or one of the health maintenance organizations available in your service area. Remember, if you are entitled to Medicare, the SHP Economy plan, MUSC Options and the TRICARE Supplement plan are not available.

Medicare Before Age 65

If you are entitled to Medicare due to disability before age 65, **you must notify EIP within 31 days of Medicare entitlement** to be advised of your options and to receive coordination of benefits with Medicare. Should you become entitled to Medicare prior to age 65, you must notify EIP immediately.

Sign up for Medicare!

You must enroll in both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. **You should enroll in Medicare Part B if you are covered through the retiree group since these plans will coordinate with Part B benefits regardless of your Medicare status.**

How Medicare Assignment Works

Under Medicare assignment, the Medicare subscriber agrees to have Medicare's share of the cost of services paid directly ("assigned") to a provider. Participating providers have agreed to submit all

their Medicare claims on an assigned basis. Non-participating providers may choose whether to accept assignment on each individual claim. If you receive services from a non-participating physician, ask if he will accept assignment.

Doctors and suppliers have the opportunity each year to participate in the Medicare program. Those that participate will always accept the Medicare-approved amount as payment in full. Some doctors choose to accept assignment, some do not. If a doctor does not accept assignment, you may end up paying more for his or her services.

If a doctor decides to participate, the contract is good all year (the doctor cannot decide in the middle of the year to no longer participate). Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

Your Plan Choices

When you and/or your eligible dependents are covered under retiree group health insurance and become entitled to Medicare, **Medicare becomes the primary payer,** and your options change. The state offers you and your eligible dependents a choice between two SHP options—the *Standard* plan or the *Medicare Supplemental* plan. *If you choose the Medicare Supplemental plan, the person(s) without Medicare will have claims paid through the Standard plan's provisions.* If you prefer, you may select an HMO if available in your area, to meet a variety of health care needs. Contact the HMO for information.

Health Plans Available in South Carolina, By Service Area

AREA	COUNTY	HEALTH PLAN CHOICES
1	Anderson, Greenville, Oconee, Pickens	State Health Plan, Companion-Choices, CIGNA HMO
2	Cherokee, Spartanburg, Union	State Health Plan, Companion-Choices, CIGNA HMO
3	Chester, Lancaster, York	State Health Plan, Companion HMO, CIGNA HMO
4	Abbeville, Greenwood, Laurens, McCormick, Saluda	State Health Plan, Companion HMO
5	Fairfield, Kershaw, Lexington, Newberry, Richland	State Health Plan, Companion HMO, CIGNA HMO
6	Aiken, Barnwell, Edgefield	State Health Plan, Companion HMO
7	Allendale, Bamberg, Calhoun, Orangeburg	State Health Plan, Companion HMO, CIGNA HMO
8	Clarendon, Lee, Sumter	State Health Plan, Companion HMO, CIGNA HMO
9	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	State Health Plan, Companion HMO, CIGNA HMO
10	Georgetown, Horry	State Health Plan, Companion HMO, CIGNA HMO
11	Berkeley, Charleston, Colleton, Dorchester	State Health Plan, Companion HMO, CIGNA HMO, MUSC Options*
12	Beaufort, Hampton, Jasper	State Health Plan, Companion HMO, CIGNA HMO

Health Plans Available out of South Carolina

If you live out of South Carolina, you may choose the State Health Plan Standard plan or the Medicare Supplemental plan.

*MUSC Options Not Available

Please note that MUSC Options is no longer available if you or your covered dependents are entitled to Medicare. You will need to choose another health plan.

TRICARE for Life

If you are a military retiree or an eligible spouse or dependent of a military retiree and you have Medicare Part B, you should also be entitled to TRICARE For Life. TRICARE For Life acts as a supplemental insurance to Medicare. If you are eligible for TRICARE For Life, but your dependents are not, they may continue their coverage under TRICARE (Standard, Extra or Prime).

If you have other insurance such as the State Health Plan (SHP), TRICARE For Life will be the third payer after Medicare and the SHP. Please review your benefits under TRICARE For Life versus the SHP. For more information call TRICARE at 888-343-5433. If you have TRICARE For Life and wish to drop your SHP coverage, you should notify EIP to request a Notice of Election (NOE) form or submit a written request of cancellation.

TRICARE Supplement Not Available

Please note that the TRICARE Supplement plan is no longer available if you are entitled to Medicare. You will need to choose another health plan. If you are eligible for TRICARE For Life, but your dependents are not, they are no longer able to continue their TRICARE Supplement plan coverage through EIP. However, their coverage is portable by paying the full cost to ASI, administrator for TRICARE Supplement plan. Contact ASI at 800-638-2610, ext. 255, for additional information.

The SHP's Standard Plan and Medicare

This section explains briefly the key distinctions of the State Health Plan (SHP) when you are entitled to Medicare. For a more complete overview of the SHP and benefits offered, refer to your Insurance Benefits Guide, which is available from your employer or from the Employee Insurance Program (EIP).

Deductibles and Coinsurance

The Standard plan benefit period is from January 1 through December 31 and includes an annual deductible of $350 per individual, or $700 per family. A $10 per visit deductible* applies for each office visit. An additional $125 per occurrence deductible* applies for each emergency room visit, unless you are admitted to the hospital. A separate $75 per occurrence deductible* applies to each outpatient hospital visit (this deductible is waived for emergency room, dialysis, oncology and physical therapy visits). After you meet the annual deductible, benefits are covered at 80 percent of the allowed charges. When you and/or your covered dependents are entitled to Medicare, the carve-out method of claims payment applies (explained on Page 7).

**Does not apply toward the annual deductible or the out-of-pocket maximum.*

SHP Hospital Network

When you are entitled to Medicare, Medicare is the primary payer and you may go to any hospital you choose. Medicare limits the number of days it will cover for hospital stays. If you are enrolled in the Standard plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the SHP network or BlueCard

Program (BlueCross BlueShield provider network) so that you will not be charged more than what the Standard plan allows. *Note: Mental health and substance abuse services are covered only at APS Healthcare, Inc., participating facilities.*

SHP Physician Network

You may want to note that while you are not generally covered outside the United States under Medicare, you have worldwide coverage as part of the BlueCard Program under the SHP's Standard plan.

Using Medi-Call When You Have Medicare

Medicare has its own utilization review program. However, you will still need to call Medi-Call when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside of the state or country), and for extended care services such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services. *Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call Medi-Call.*

Private Duty Nursing

Private duty nursing services provided by a registered nurse (RN) or a licensed practical nurse (LPN) that have been certified in writing by a physician as medically necessary are allowed. These services are NOT covered by Medicare. Once the annual deductible is met, the SHP Standard plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is $5,000. The lifetime maximum benefit under the Standard plan is $25,000.

When Traveling Out of South Carolina

If you are admitted to a hospital outside of the state or country as a result of an emergency, notify Medi-Call and follow the BlueCard Program guidelines.

Mental Health and Substance Abuse: Using APS

If you are entitled to Medicare and covered under the Standard plan, you must call APS Healthcare, Inc. (APS), administrator of the SHP Mental Health and Substance Abuse benefits, at 800-221-8699 for approval. Precertification and continued stay authorizations by APS are required for all services. To receive benefits, you must use an APS network provider. Note: *Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must also call to register with APS and use an APS network provider.*

Prescription Drug Program

Medicare does not provide coverage for prescription drugs, except in a few cases, like certain cancer drugs. The Standard plan covers prescription drugs when purchased from a participating pharmacy. Additional information regarding the SHP Prescription Drug Program may be found in your *Insurance Benefits Guide.*

Ambulatory Surgical Center Network

If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a center that participates in the network.

Transplant Contracting Arrangements

As part of this network under the SHP, you have access to the leading transplant facilities in the nation, including instate providers of transplant services. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a facility that participates in the SHP network.

Mammography Testing Benefit

The SHP allows female subscribers ages 35-74 to have routine mammograms—one baseline mammogram if you are age 35-39, one routine mammogram every other year if you are age 40-49 and one routine mammogram every year if you are age 50-74—at no cost if you use a facility that participates in the program's network.

Medicare allows yearly routine mammograms for women age 40 and older and pays 80 percent of Medicare-approved charges. Check with the testing facility to see if it accepts Medicare assignment.

Pap Test Benefit

The SHP will pay for yearly Pap tests for covered women ages 18-65. The Pap test benefit applies whether the Pap test is routine or diagnostic. The deductible and coinsurance do not apply to this benefit. This benefit does not include the doctor's office visit or other lab tests. Medicare covers a Pap test, pelvic exam and clinical breast exam every other year (yearly, if you are at high risk. Check with Medicare for more information). Medicare pays 100 percent for the test; 80 percent for the exam and collection.

Maternity Management & Well Child Care

The SHP offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be, who are covered by the SHP, receive necessary prenatal care. (This benefit applies to covered retirees and spouses; it does not apply to dependent children). The Well Child Care benefit offers coverage for routine checkups and immunizations of children through age 12. Medicare does not provide similar coverage. Refer to your *Insurance Benefits Guide* for more information on these benefits.

"Carve-out" Method of Claims Payment

The Standard plan coordinates with Medicare on the basis of the SHP-approved charge. The carve-out method of claims payment works just like coordination of benefits with any other plan when an individual is covered by two insurance plans—one pays first and the other pays second. If your provider accepts Medicare assignment, the Standard plan will pay the lesser of:

1. The Medicare-allowed amount less the Medicare-reported payment; or
2. The SHP-allowed amount less the Medicare-reported payment.

If your provider does not accept Medicare assignment, the Standard plan pays the difference between the SHP's allowable amount and the amount Medicare reported paying. If the Medicare payment exceeds the SHP's allowable amount, the Standard plan will not pay a benefit. The Standard plan will never pay for charges that are more than the SHP's allowable amount. With the Standard plan, your total benefits (Medicare plus the SHP) will be equivalent to those offered to active employees and retirees not entitled to Medicare.

***Example**:*
Hospital bill for a January admission is $7,500:

$7,500	Hospital bill
- 876	Medicare Part A deductible for 2004
$6,624	Medicare payment
$ 876	You pay (unless you have another health insurance plan)

If you are enrolled in the Standard plan your claim will be processed like this:

$7,500	Hospital bill
- 350	Standard plan deductible for 2004
7,150	Standard plan liability
x 80%	Standard plan coinsurance
$5,720	Amount the plan would pay in the absence of Medicare
- 6,624	Amount paid by Medicare
$ -0-	Standard plan pays nothing; you pay the lesser of 20 percent or balance of bill*

You pay the 20 percent coinsurance or the balance of the bill, whichever is less. In this example, your 20 percent coinsurance of $1,430, plus the $350 deductible, is $1,780; however, the balance of the bill is only $876, so you pay $876. Once you reach your $2,000 coinsurance maximum, all claims will be allowed at 100 percent of the **allowable charge based on the carve-out method of claims payment.*

Filing Claims

Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Incurred in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP for you through the BlueCard Program. Your mental health and substance abuse provider should file claims for you with APS, including Medicare payment information. Occasionally, if you do not receive an Explanation of Benefits from BCBSSC or APS after a reasonable length of time, you may need to refile your claim, by sending in a completed claim form and a copy of your Explanation of Medicare Benefits (EOMB) with your subscriber identification number written on it.

Claims Incurred Outside South Carolina

If you receive services outside of South Carolina, your claim should be transferred automatically from Medicare to the SHP for you through the BlueCard Program. For mental health and substance abuse services, you will need to send a copy of your EOMB to APS, along with a claim form and itemized bill. Contact APS at 800-221-8699 for a claim form.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BCBSSC or APS. Be sure to attach a copy of the EOMB and itemized bill.

The Medicare Supplemental Plan and Medicare

This section explains briefly the State Health Plan's (SHP) Medicare Supplemental plan, which is available to retirees and covered dependents who are entitled to Medicare. Additional information may be found in your *Insurance Benefits Guide*.

General Information

The Medicare Supplemental plan is similar to a Medigap policy—it fills the "gap" or pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental plan adheres to Medicare-approved charges. If your medical provider does not accept Medicare assignment and charges you more than what Medicare allows, you pay the difference. You may enroll in this plan when you retire or during a designated enrollment period for the Medicare Supplemental plan. If you are enrolled in a health plan, you may change to the Medicare Supplemental plan within 31 days of entitlement to Medicare. Designated Medicare Supplemental plan enrollment periods are held every other October on the odd year (2005). During this time, you can change from the Standard plan to the Medicare Supplemental plan or vice versa. Plan changes are effective on the first of January following the enrollment period.

Medicare Deductibles and Coinsurance

Deductibles

Medicare Part A has an inpatient hospital deductible for each benefit period. That deductible is $876 for 2004. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental plan pays the Part A deductible.*

Medicare Part B has a deductible of $100 per year. Part B also includes a monthly premium of $66.60 for 2004 and covers physician services, supplies and outpatient care. As a retiree or a covered dependent of a retiree, you should enroll in Part B as soon as you are entitled to Medicare, as Medicare becomes primary. *The Medicare Supplemental plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of Medicare-approved charges (50 percent for outpatient mental health care). *The Medicare Supplemental plan pays the remaining 20 percent (50 percent for outpatient mental health care).*

Medicare Supplemental Plan Deductibles and Coinsurance

The Medicare Supplemental plan benefit period is from January 1 - December 31 and includes a $200 deductible each calendar year that applies to private duty nursing services only. If you become entitled to Medicare and change to the Medicare Supplemental plan during the year, you must meet a new $200 deductible for private duty nursing services. You do not have to meet another $200 deductible for private duty nursing services if you retain the Standard plan.

The Medicare Supplemental plan pays only Medicare-approved charges. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan will also pay the 20 percent coinsurance after Medicare pays 80 percent for Part B-approved services.

Hospital Admissions

The Medicare Supplemental plan pays the following benefits for Medicare-covered services after Medicare Part A benefits have been paid during a benefit period:

- The Medicare Part A hospital deductible;
- The coinsurance, after Medicare pays, for days 61-150 of hospitalization, up to the Medicare-approved charge (Medicare pays 100 percent for the first 60 days);
- 100 percent of Medicare-approved charges for hospitalization beyond 150 days, if medically necessary (Medicare does not pay beyond 150 days)*;
- The coinsurance for durable medical equipment up to the Medicare-approved charge*.

**Must call Medi-Call for approval.*

Skilled Nursing Facilities

The Medicare Supplemental plan will pay the following benefits after Medicare has paid benefits during a benefit period:

- The coinsurance, after Medicare pays, up to the Medicare-approved charge for days 21-100 (Medicare pays 100 percent for the first 20 days);
- 100 percent of the Medicare-approved charges beyond 100 days in a skilled nursing facility if medically necessary (Medicare does not pay beyond 100 days).* The maximum benefit per year is $6,000.

**Must call Medi-Call for approval.*

Physician Charges

The Medicare Supplemental plan will pay the following benefits related to physician services approved by Medicare:

- The Medicare Part B deductible;
- The coinsurance of the Medicare-approved charge for physician's services for surgery, necessary home and office visits, in hospital visits and other covered physician's services;
- The coinsurance for Medicare-approved charges for physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

Home Health Care

The Medicare Supplemental plan will pay the following benefits for medically necessary home health care services:

- The Medicare Part B deductible;
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent for Medicare-approved charges), up to 100 visits or $5,000 per benefit year, whichever occurs first.

The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or is a member of the family of the spouse of the covered person.

Private Duty Nursing Services

Private duty nursing services provided by a registered nurse (RN) or a licensed practical nurse (LPN) that have been certified in writing by a physician as medically necessary are allowed. There is a $200 annual deductible that applies, regardless of the time of year you enroll in the plan. These services are NOT covered by Medicare. Once the deductible is met, the Medicare Supplemental plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is $5,000. The lifetime maximum benefit under the Medicare Supplemental plan is $25,000.

Prescription Drugs

Although Medicare does not provide coverage for prescription drugs, except in a few cases, like certain cancer drugs, the Medicare Supplemental plan covers prescription drugs when purchased from a participating pharmacy under the SHP's Prescription Drug Program, administered by Medco Health Solutions, Inc. Additional information regarding the Prescription Drug Program may be found in your *Insurance Benefits Guide*.

Diabetic Supplies

Medicare covers some diabetic supplies for people with Medicare with diabetes (insulin users and non-insulin users). These include limited quantities of:

- Blood glucose test strips (All Medicare enrolled pharmacies and suppliers must submit claims for glucose monitor test strips. You cannot send in the claim for glucose test strips yourself.);
- Blood glucose meter;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of test strips monitors.

For more information on how Medicare covers diabetic supplies, go to Medicare's Web site at www.medicare.gov.

Hospital Visits

If you are entitled to Medicare, Medicare is the primary payer, and you may go to any hospital you

choose. However, Medicare limits the number of days it will cover you for hospital stays—Medicare pays nothing for hospital stays beyond 150 days.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare
If you are enrolled in the Medicare Supplemental plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call for approval of any additional inpatient hospital days. If your extended stay is approved, the Medicare Supplemental plan will pay for the Medicare-approved expenses. So, if you are enrolled in the Medicare Supplemental plan and you expect your hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP network or BlueCard program so that any additional days beyond what Medicare allows will be covered by the Medicare Supplemental Plan. *Note: Mental health and substance abuse services are covered at APS Healthcare, Inc., participating facilities.*

You must also call Medi-Call for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

When Traveling Outside the U.S.

Although the SHP hospital network also includes participating hospitals across the country and around the world through the BlueCard Program, administered by BlueCross BlueShield of South Carolina, Medicare does not cover services outside the United States. Since the Medicare Supplemental plan does not allow benefits for services not covered by Medicare (other than prescription drugs and private duty nursing), the BlueCard Program does not apply to Medicare Supplemental plan subscribers. It will apply, however, to a covered spouse or dependent who is not eligible for Medicare.

Using Medi-Call

Medicare has its own utilization review program. You will need to call Medi-Call only when Medicare benefits are exhausted for inpatient hospital services and for extended care services such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services. *Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call Medi-Call.*

Mental Health and Substance Abuse

If your claims are processed under the Medicare Supplemental plan, you do not need to call APS, administrator of the SHP Mental Health and Substance Abuse benefit, because Medicare guidelines will apply. However, if you exhaust Medicare's allowed inpatient hospital days, you must call APS for approval of any additional inpatient hospital days. Precertification and continued stay authorizations from APS are required for inpatient care; however, you are not required to use an APS network provider. *Note: Any covered family members who are not entitled to Medicare and have their claims processed under the SHP must call to register with APS and use an APS network provider.*

Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes facilities throughout the state that provide some of the same services as provided in the outpatient departments of hospitals. These centers accept the SHP's allowed charges and will not charge you more. If you are entitled to Medicare, there is no

need to call Medi-Call for precertification, nor do you need to select a center that participates in the SHP network.

Transplant Contracting Arrangements

As part of this network under the SHP, you have access to the leading transplant facilities in the nation, including instate providers of transplant services. If you are entitled to Medicare, there is no need to call Medi-Call for precertification, nor do you need to select a facility that participates in the SHP network.

Mammography Testing Benefit

If you are entitled to Medicare, Medicare allows yearly routine mammograms for women ages 40 and older and pays 80 percent of the Medicare-approved amount. The Medicare Supplemental plan pays the 20 percent coinsurance.

Pap Test Benefit

If you are entitled to Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year (yearly, if you are at high risk. Check with Medicare for more information). Medicare pays 100 percent for the Pap lab test; 80 percent of the Medicare-approved amount for the Pap test collection and the pelvic and breast exam. The Medicare Supplemental plan pays the 20 percent coinsurance.

Please note that the Medicare Supplemental plan will pay for Pap tests for covered women, ages 18-65, *every year,* so you may take advantage of this benefit in the years that Medicare does *not* pay. The Pap test benefit applies whether or not the Pap test is routine or diagnostic. The deductible and coinsurance do not apply to this first-dollar benefit. This benefit does not include the doctor's office visit or other lab tests.

Maternity Management & Well Child Care Benefits

The Medicare Supplemental plan offers benefits geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be covered by the SHP receive necessary prenatal care. (This benefit applies to covered retirees and spouses; it does not apply to dependent children). The Well Child Care benefit offers coverage for routine checkups and immunizations of children through age 12. If you are entitled to Medicare, know that Medicare does not provide similar coverage. Additional information regarding the Maternity Management and Well Child Care benefits may be found in your *Insurance Benefits Guide.*

How the Medicare Supplemental Plan Works Together with Medicare

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 876	Medicare Part A deductible for 2004
$6,624	Medicare payment
$ 876	You pay (unless you have another health insurance plan)

The Medicare Supplemental plan will pay all Medicare deductibles and coinsurance:

$ 876	Medicare Supplemental plan pays Medicare Part A deductible
+6,624	Amount paid by Medicare
$ 7,500	Bill paid in full

Medicare Assignment
If the provider accepts Medicare assignment (assigned claims), the provider accepts Medicare's payment plus the Medicare Supplemental plan's payment as payment in full. If the provider does not accept Medicare assignment (non-assigned claim), the provider may charge more than what Medicare and the Medicare Supplemental plan pay combined. You would pay the difference.

Filing Claims

If you are entitled to Medicare, Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Incurred in South Carolina
The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP for you. Your mental health and substance abuse provider should file claims to APS, including Medicare payment information. Occasionally, if you do not receive an Explanation of Benefits from BCBSSC or APS after a reasonable length of time, you may need to refile your claim by sending in a completed claim form and a copy of your Explanation of Medicare Benefits (EOMB) with your subscriber identification number written on it

Claims for covered family members not entitled to Medicare but insured through the Medicare Supplemental plan are paid through the Standard plan provisions. The carve-out method of claims payment does not apply to family members who are not entitled to Medicare.

Claims Incurred Outside South Carolina
If you receive services outside of South Carolina, your provider will file its claim to the Medicare carrier in that state. When you receive your EOMB, you must send it to BCBSSC for medical or surgical services or APS for mental health and substance abuse services along with a claim form and itemized bill. BCBSSC claim forms are available on the EIP Web site at www.eipsc.gov; call APS at 800-221-8699 for an APS claim form.

If Medicare Denies Your Claim
If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BCBSSC. Benefits are not payable by APS for mental health and substance abuse claims denied by Medicare.

HMO Plans and Medicare

This section explains some key distinctions of the health maintenance organizations (HMOs) and how they work together with Medicare. For a more complete overview of the plans, refer to the HMO section of this guide or contact the HMO.

Remember, you must live in an HMO or POS plan's service area to enroll. Not all HMOs or POS plans are available in all service areas. A list of service areas may be found on Page 4.

MUSC Options Not Available

MUSC Options is **not** available if you or your covered dependents are entitled to Medicare. However, the Companion HMO, Companion-CHOICES POS and CIGNA HMO plans are available if you live in their service area.

Provider Networks

Traditional HMOs provide a list of participating network doctors from which you choose a primary care physician. This doctor coordinates your care, which means you must contact him to be referred to specialists who also participate within the HMO's network. Network providers file the claims for you. If you belong to an HMO, the plan covers only medical services received within its network of providers. If you receive care outside of the network, benefits are not paid. Typically, the only services you receive from out-of-network providers that most HMOs cover are those for emergency medical conditions.

A POS plan is an HMO plan that allows you to selectively go to a provider outside of its network. When you do so, you are likely to have much higher out-of-pocket expenses in the form of deductibles and copayments.

When Traveling Outside of the Network or U.S.

When traveling outside the CIGNA or Companion networks, you will be covered for emergency medical care. If your insurance identification cards are not recognized by the treating hospital, you may be required to pay for the services, then later file a claim for reimbursement.

Prescription Drug Programs

Medicare does not provide coverage for prescription drugs, except in a few cases like certain cancer drugs. However, the HMOs and POS plans offered for 2004 include a prescription drug program with participating pharmacies.

How Companion HMO and Companion-CHOICES POS Work Together With Medicare

Companion HealthCare's (Companion) health maintenance organization (Companion HMO), with or without the Point of Service (Companion-CHOICES) option pays only Medicare-approved

charges. Both supplement Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plans also pay the 20 percent coinsurance left after Medicare pays 80 percent for Part B-approved services.

These two plans pay the coinsurance days for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and the first 20 days of skilled nursing care). Companion also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment (assigned claims), the provider accepts Medicare's payment plus Companion's payment as payment in full. If the provider does not accept Medicare assignment (non-assigned claim), the provider may charge more than what Medicare and Companion pay combined. The subscriber would pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 876	Medicare Part A deductible for 2004
$6,624	Medicare payment
$ 876	You pay (unless you have another health insurance plan)

Companion pays all Medicare deductibles and coinsurance:

$ 876	Companion pays Medicare Part A deductible
+6,624	Amount paid by Medicare
$7,500	Bill paid in full

How CIGNA HMO Works Together With Medicare

CIGNA's HMO pays the lesser of the subscriber's unreimbursed allowable expense under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, then CIGNA will pay the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the portion of the payment that CIGNA does not have to pay out as part of its normal liability as a result of a coordination of benefits with Medicare. It may be applied as credit toward future claims within the calendar year. *Benefit credit saving* is the difference between CIGNA's normal liability and CIGNA's actual payment. Benefit credit saving applies only to the family member who incurs the charge, and it expires at the end of the calendar year in which it is gained. Contact CIGNA HealthCare for additional information.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 876	Medicare Part A deductible
$6,624	Medicare payment
$ 876	Balance due

If you are enrolled in CIGNA's HMO plan your claim will be paid like this:

$7,500	Hospital bill
- 500	CIGNA's inpatient per occurrence copayment for 2004
$7,000	
x 80%	CIGNA's coinsurance
$5,600	CIGNA's liability in absence of Medicare
- 876	Amount paid by CIGNA in coordination with Medicare
$4,724	Benefit credit savings with CIGNA

Filing Claims

If you are entitled to Medicare, Medicare is the primary carrier. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

For more information, contact the HMO. Contact information may be found on Page 25.

Comparison of Health Plan Benefits for

TYPE			PPO To receive a higher level of benefits, subscribers should choose an in-network provider
PLAN	**MEDICARE**	**MEDICARE SUPPLEMENTAL**	**SHP STANDARD PLAN**
SERVICE AREAS	United States (Contact Medicare for information about services outside the United States)	Same as Medicare	Coverage worldwide
CANCELLATION POLICY	None	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums
ANNUAL DEDUCTIBLE	Part A: $876 (per benefit period) Part B: $100	Pays Medicare Part A and Part B deductibles	$350 (single) $700 (family) Carve-out method applies
PER OCCURRENCE DEDUCTIBLE	Inpatient hospital: Part A deductible ($876 per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home health care, durable medical equipment and VA hospital services)	Outpatient hospital: $75 deductible Emergency care: $125 deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home health care, durable medical equipment and VA hospital services)
COINSURANCE	Part A: 100% Part B: 80% (you pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%
COINSURANCE MAXIMUM	None	None	$2,000 (single) $4,000 (family) (excludes deductible)
PHYSICIAN VISITS	Plan pays 80% You pay 20% Routine annual physicals and OB/GYN exams not covered	Plan pays Part B coinsurance of 20%	Carve-out method applies; $10 per visit deductible; Plan allows 80% in-network, 60% out-of-network Well child care visits & immunizations paid at 100% in-network to age 12
PRESCRIPTION DRUGS	No coverage, except for certain cancer drugs	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Copayment Max: $2,500	Participating pharmacies only: $10 generic $25 preferred brand $40 nonpreferred brand (up to 31-day supply) Mail-order (up to 90-day supply): $23 generic, $56 preferred brand; $90 non-preferred brand Copayment Max: $2,500
MENTAL HEALTH/ SUBSTANCE ABUSE	Inpatient: Plan pays 100% for days 1-60 (Part A deductible applies); You pay $210/day for days 61-90; You pay $420/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days. Outpatient: Plan pays 50% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days (APS approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	Plan allows 80% (APS participating providers only if hospital stay exceeds 150 days) (carve-out method applies)
LIFETIME MAXIMUM	None	$1,000,000	$1,000,000

Retirees and Dependents Entitled to Medicare

TRADITIONAL HMO		HMO WITH POINT OF SERVICE (POS) OPTION	
All care must be directed by a primary care physician (PCP) and approved by the HMO.		To receive the higher level of benefits, care must be directed by a primary care physician (PCP) and approved by the HMO. Medically necessary benefits are available out-of-network at a lower benefit level.	
COMPANION HMO	**CIGNA HMO**	**COMPANION-CHOICES POS**	
Service areas: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	Service areas: 1, 2, 3, 5, 7, 8, 9, 10, 11, 12	Service areas: 1, 2	
Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	Cancelled upon request or for non-payment of premiums	
Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbursed Medicare-allowed expense or plan's normal allowance	**In-network** Pays Medicare Part A and Part B deductibles	**Out-of-network** Pays Medicare Part A and Part B deductibles
Pays Medicare Part A deductible	Inpatient: $500 copay Outpatient facility: $250 copay Emergency care: $100 copay	Pays Medicare Part A deductible	Pays Medicare Part A deductible
Pays Part B coinsurance of 20%	Plan pays 80% or unreimbursed Medicare-allowed expense	Pays Part B coinsurance of 20%	Pays Part B coinsurance of 20%
None	$3,000 (single) $6,000 (family) (excludes certain copays)	None	None
Plan pays Part B coinsurance of 20%	$20 PCP copayment $40 OB/GYN well woman exam; $40 specialist copay Plan pays 80% or unreimbursed Medicare-allowed expense	Plan pays Part B coinsurance of 20%	Plan pays Part B coinsurance of 20%
Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply): $21 generic; $75 preferred brand; $120 non-preferred brand No copayment Max	Participating pharmacies only: $10 generic $20 preferred brand $50 nonpreferred brand (30-day supply) Mail-order (up to 90-day supply): $20 generic; $40 preferred brand name; $100 non-preferred brand name No copayment Max	Participating pharmacies only (Generics First): $7 generic $25 preferred brand $40 nonpreferred brand $75 specialty pharmaceuticals (31-day supply) Mail-order (up to 90-day supply): $21 generic; $75 preferred brand; $120 non-preferred brand No copayment Max	
Inpatient: Plan pays Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days. Outpatient: Plan pays Medicare deductible, 50% coinsurance	Participating providers only. Inpatient: $500 copay; Outpatient: $40 specialist copay Plan pays 80% or unreimbursed Medicare-allowed expense.	Inpatient: Plan pays Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	
$1,000,000	$1,000,000	$1,000,000	

Comparison of Health Plan Benefits for Retirees

			PPO
PLAN	**MEDICARE**	**MEDICARE SUPPLEMENTAL**	**SHP STANDARD PLAN**
INPATIENT HOSPITAL DAYS[1]	Plan pays 100% for days 1-60 (Part A deductible applies); You pay $219/day for days 61-90; You pay $438/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days.	Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required)	Plan allows 80% (carve-out method applies) (Call Medi-Call if hospital stay exceeds 150 days)
SKILLED NURSING CARE	Plan pays 100% for days 1-20; You pay $109.50 for days 21-100	Plan pays $109.50 for days 21-100; Plan pays 100% beyond 100 days (Medi-Call approval required)	Plan allows 80% (carve-out method applies), up to $6,000 or 60 days, whichever is less. (Call Medi-Call if hospital stay exceeds 100 days)
PRIVATE DUTY NURSING	Not covered	$200 annual deductible Plan pays 80% if Medi-Call approved You pay 20% $5,000 annual max./$25,000 lifetime	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call approval required)
HOME HEALTH CARE	Plan pays 100%	Medi-Call available to assist with referrals	Plan allows 80% (carve-out applies)You pay 20% up to $5,000 or 100 visits, whichever is less
HOSPICE CARE	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
DURABLE MEDICAL EQUIPMENT	Plan pays 80% (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Plan allows 80% (carve-out applies) (Medi-Call approval required)
ROUTINE MAMMOGRAPHY SCREENING	Age 40 and older, one every year Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Ages 35 through 74 in participating facilities only; guidelines apply
PAP TEST	Routine every two years (yearly if high risk) Plan pays 100% for Pap test Plan pays 80% for exam	Plan pays 20% coinsurance. Otherwise, pays routine ages 18 through 65 routine or diagnostic; diagnostic only age 66 and older	Routine yearly ages 18 through 65 routine; diagnostic only age 66 and older; Plan allows 100% for Pap test (carve-out applies when Medicare pays)
AMBULANCE	Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Plan allows 80% (carve-out method applies)
EYEGLASSES/ HEARING AID	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under Vision Care Program

[1]Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing and miscellaneous hospital services and supplies.

and Dependents Entitled to Medicare (cont.)

TRADITIONAL HMO		HMO WITH POINT OF SERVICE (POS) OPTION	
COMPANION HMO	CIGNA HMO	COMPANION-CHOICES	
Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days	Plan pays 80% or unreimbursed Medicare-allowed expense after $500 copay	**In-network** Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days	**Out-of-network** Plan pays: Medicare deductible; $210 coinsurance for days 61-90; $420 coinsurance for days 91-150; 100% beyond 150 days
Plan pays $109.50 for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays 80% or unreimbursed Medicare-allowed expense, up to 180 days	Plan pays $109.50 for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays $109.50 for days 21-100; Plan pays 100% beyond 100 days
Plan pays 80%; You pay 20% and $200 annual deductible $5,000 annual max./$25,000 lifetime (limited to 120 days)	Plan pays 100%	Plan pays 80%; You pay 20% and $200 annual deductible $5,000 annual max./$25,000 lifetime (limited to 120 days)	Plan pays 80% ; You pay 20% and $200 annual deductible $5,000 annual max./$25,000 lifetime
(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense, up to 60 visits	(Medicare pays 100% of covered charges)	(Medicare pays 100% of covered charges)
(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expense	(Medicare pays 100% of covered charges)	(Medicare pays 100% of covered charges)
Plan pays 20% coinsurance	$3,500 maximum Plan pays 100% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance
Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance
Plan pays 20% coinsurance. Otherwise, pays routine any age; 2 per year; $15. Diagnostic: copay/coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expense after $25 copay	Plan pays 20% coinsurance. Otherwise, pays routine any age; 2 per year; $15. Diagnostic: copay/coinsurance	Plan pays 20% coinsurance. Otherwise, covered in-network only
Plan pays 20% coinsurance	Plan pays 90% or unreimbursed Medicare-allowed expense	Plan pays 20% coinsurance	Plan pays 20% coinsurance
One exam for glasses or contacts per year ($45 copay for contacts exam). One pair glasses every other year (from designated selection)	One exam every two years ($10 copay). Must use participating provider.	Plan pays up to $75 for routine eye exam once per benefit period Plan pays up to $75 for eyewear once every other per benefit period	

2004 Regular Retiree (State-Funded Benefits) Monthly Premiums[1]

(Retiree entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree	N/A	$ 54.78	$ 72.78	$ 77.08	$ 74.56	N/A	$ 86.10	$ 0.00	$17.50
Retiree/spouse	N/A	$162.52	$198.52	$218.46	$213.10	N/A	$238.38	$ 7.64	$33.14
Retiree/children	N/A	$ 91.80	$109.80	$179.36	$175.10	N/A	$195.08	$13.72	$36.16
Full family	N/A	$199.54	$235.54	$382.86	$375.62	N/A	$410.08	$21.34	$51.80

(Retiree entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$174.86	$192.86	$218.46	$213.10	N/A	$238.38	$ 7.64	$33.14
Full family	N/A	$219.96	$237.96	$382.86	$375.62	N/A	$410.08	$21.34	$51.80

(Retiree not entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$177.24	$195.24	$218.46	$213.10	N/A	$238.38	$ 7.64	$33.14
Full family	N/A	$214.26	$232.26	$382.86	$375.62	N/A	$410.08	$21.34	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree	$ 66.48	$ 69.50	N/A	$ 77.08	$ 74.56	$ 72.28	$ 86.10	$ 0.00	$17.50
Retiree/spouse	$170.12	$189.58	N/A	$218.46	$213.10	$194.68	$238.38	$ 7.64	$33.14
Retiree/children	$ 96.10	$106.52	N/A	$179.36	$175.10	$143.36	$195.08	$13.72	$36.16
Full family	$206.20	$234.68	N/A	$382.86	$375.62	$296.08	$410.08	$21.34	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare/one or more children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree/children	N/A	$106.52	$124.52	$179.36	$175.10	N/A	$195.08	$13.72	$36.16
Full family	N/A	$234.68	$252.68	$382.86	$375.62	N/A	$410.08	$21.34	$51.80

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard plan provisions.

2004 Retiree Full Cost (Non-Funded) Monthly Premiums[1]

(Retiree entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree	N/A	$261.48	$279.48	$283.78	$281.26	N/A	$292.80	$11.71	$17.50
Retiree/spouse	N/A	$566.64	$602.64	$622.58	$617.22	N/A	$642.50	$19.35	$33.14
Retiree/children	N/A	$404.40	$422.40	$491.96	$487.70	N/A	$507.68	$25.43	$36.16
Full family	N/A	$666.26	$702.26	$849.58	$842.34	N/A	$876.80	$33.05	$51.80

(Retiree entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$578.98	$596.98	$622.58	$617.22	N/A	$642.50	$19.35	$33.14
Full family	N/A	$686.68	$704.68	$849.58	$842.34	N/A	$876.80	$33.05	$51.80

(Retiree not entitled to Medicare/spouse entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree/spouse	N/A	$581.36	$599.36	$622.58	$617.22	N/A	$642.50	$19.35	$33.14
Full family	N/A	$680.96	$698.98	$849.58	$842.34	N/A	$876.80	$33.05	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree	$273.18	$276.20	N/A	$283.78	$281.26	$278.98	$292.80	$11.71	$17.50
Retiree/spouse	$574.24	$593.70	N/A	$622.58	$617.22	$598.80	$642.50	$19.35	$33.14
Retiree/children	$408.70	$419.12	N/A	$491.96	$487.70	$455.96	$507.68	$25.43	$36.16
Full family	$672.92	$701.40	N/A	$849.58	$842.34	$762.80	$876.80	$33.05	$51.80

(Retiree not entitled to Medicare/spouse not entitled to Medicare/one or more children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Retiree/children	N/A	$419.12	$437.12	$491.96	$487.70	N/A	$507.68	$25.43	$36.16
Full family	N/A	$701.40	$719.40	$849.58	$842.34	N/A	$876.80	$33.05	$51.80

[1]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]If the Medicare Supplemental plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard plan provisions.

2004 Survivor Monthly Premiums[1]

(Spouse entitled to Medicare/children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Spouse	N/A	$261.48	$279.48	$283.78	$281.26	N/A	$292.80	$11.71	$17.50
Spouse/children	N/A	$404.40	$440.40	$491.96	$487.70	N/A	$507.68	$25.43	$36.16
Children only	N/A	$142.92	$160.92[3]	$208.18	$206.44	N/A	$214.88	$13.72	$18.66

(Spouse entitled to Medicare/children not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Spouse	N/A	$261.48	$279.48	$283.78	$281.26	N/A	$292.80	$11.71	$17.50
Spouse/children	N/A	$404.40	$422.40	$491.96	$487.70	N/A	$507.68	$25.43	$36.16
Children only	$135.52	$142.92	N/A	$208.18	$206.44	$176.98	$214.88	$13.72	$18.66

(Spouse not entitled to Medicare/children entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Spouse	$273.18	$276.20	N/A	$283.78	$281.26	$278.98	$292.80	$11.71	$17.50
Spouse/children	N/A	$419.12	$437.12	$491.96	$487.70	N/A	$507.68	$25.43	$36.16
Children only	N/A	$142.92	$160.92[3]	$208.18	$206.44	N/A	$214.88	$13.72	$18.66

(Spouse not entitled to Medicare/children not entitled to Medicare)

	ECONOMY	STANDARD	SUPPLEMENTAL[2]	COMPANION	CIGNA	MUSC OPTIONS	CHOICES	DENTAL	DENTAL PLUS
Spouse	$273.18	$276.20	N/A	$283.78	$281.26	$278.98	$292.80	$11.71	$17.50
Spouse/children	$408.70	$419.12	N/A	$491.96	$487.70	$455.96	$507.68	$25.43	$36.16
Children only	$135.52	$142.92	N/A	$208.18	$206.44	$176.98	$214.88	$13.72	$18.66

[1]Plan premiums for spouses and dependents will be waived for one year after the death of the funded employee or retiree for those covered as dependents under the Plan at the time of death.
[2]If the Medicare Supplemental plan is elected, claims for covered subscribers not entitled to Medicare will be based on the Standard plan provisions.
[3]This premium applies only if one or more children are entitled to Medicare.

Who to Contact for More Information

Aetna

Long Term Care
Long Term Care, RT 52
151 Farmington Avenue
Hartford, CT 06156
Hotline:
800-537-8521
Fax 860-952-2024
www.aetna.com/group/southcarolina

APS Healthcare, Inc.

State Mental Health and Substance Abuse
Claims, State of SC
P.O. Box 1307
Rockville, MD 20849
Customer Service:
800-221-8699
Fax 888-897-8931
www.apshealthcare.com (password=statesc)

ASI

TRICARE Supplement
P.O. Box 2510
Rockville, MD 20847
Customer Service:
800-638-2610 ext 255
Fax 301-816-1125

BlueCross BlueShield of South Carolina

State Health Plan Claims
P.O. Box 100605
Columbia, SC 29260-0605
Customer Service Center:
800-868-2520
803-736-1576
Fax 803-699-7675
State Health Plan Medi-Call
Blue Cross BlueShield of SC
AF 330
I-20 Alpine Road
Columbia, SC 29219
800-925-9724
803-699-3337
Fax 803-264-0183
State Dental Plan, Dental Plus
BlueCross BlueShield of SC
P.O. Box 100300
Columbia, SC 29202
Customer Service:
888-214-6230
Fax 803-419-3283
www.southcarolinablues.com

CIGNA HealthCare HMO

P.O. Box 5200
Scranton, PA 18505-5200
Member Services:
800-244-6224
www.cigna.com

Companion HealthCare HMO/POS

Member Services
P.O. Box 6170
AX-435
Columbia, SC 29260-6170
Member Services:
800-868-2528
803-786-8476
www.companionhealthcare.com

Employee Insurance Program

P.O. Box 11661
Columbia, SC 29211-1661
Customer Service:
888-260-9430
803-734-0678
Retiree Billing:
803-734-1696
Fax 803-737-0825
www.eip.sc.gov

Fringe Benefits Management Company

MoneyPlu$
P.O. Box 1878
Tallahassee, FL 32302-1878
3101 Sessions Road
Tallahassee, FL 32303
800-342-8017
Automated Information:
800-865-FBMC
Claims Fax 850-425-4608
Other Fax 850-425-6220
www.fbmc-benefits.com

The Hartford

Basic Life, Optional Life, Dependent Life
Benefits Management Services
(Death Claims/AD&D)
Medical Underwriting Dept.
Group Conversion Unit
P.O. Box 2999
Hartford, CT 06104-2999
Evidence of Insurability:
800-331-7234
Death Claims:
888-563-1124
Retiree Enrollment/Claims:
888-803-7346, ext 3648
Conversion:
800-548-5157

Medco Health Solutions, Inc.

State Health Plan Prescription Drug Program
Claims—Medco Health Prescriptions
P.O. Box 2277
Lee's Summit, MO 64063-2277
Customer Service:
800-711-3450
www.medcohealth.com

Medicare

800-MEDICARE (800-633-4227)
TTY (877-486-2048)
www.medicare.gov

Social Security Administration

800-772-1213 (nationwide)
800-325-0778 (TTY)
www.ssa.gov

South Carolina Retirement Systems

mailing address:
Post Office Box 11960
Columbia, SC 29211-1960
street address:
Gressette-Collins Building
202 Arbor Lake Drive
Columbia, SC 29223
800-868-9002 (toll-free in S.C.)
803-737-6800 (Columbia)
www.retirement.sc.gov

The Standard Insurance

Basic Long Term Disability, Supplemental Long Term Disability
P.O. Box 2800
Portland, OR 97208
900 SW Fifth Avenue
Portland, OR 97204
Customer Service:
800-628-9696
Medical Evidence:
800-843-7979
Fax 800-437-0961
www.standard.com

TRICARE

Military Health Plan
800-444-5445 (Southeast region)
www.tricare.osd.mil

Glossary

Actively at Work — Employees are considered actively at work on an employer's scheduled workday if they are performing in the usual manner all of the regular duties of their work on a full-time basis on that day, whether at their usual place of work or at another place if required to travel. Employees are also considered actively at work on a paid vacation day or on a day that is not one of the employer's scheduled workdays only if they were actively at work on the preceding scheduled workdays.

Allowable Charge — The maximum amount a health plan (such as the State Health Plan, an HMO or Medicare) will pay for a covered service. Network providers and facilities are those who have agreed to accept the allowable charge for covered services under the plan.

Annual Enrollment — A period **each** year during which eligible employees and retirees may change health plans only (SHP Economy to Standard, Standard to Economy, SHP to an HMO, HMO to SHP or HMO to another HMO). No other changes are allowed. Health plan changes are allowed each annual enrollment period with the exception of changing to or from the TRICARE Supplement plan and retirees changing to or from the Medicare Supplemental plan. See also *Open Enrollment*.

Basic Salary — The actual amount for which an employee is compensated by the employer per year, including merit and longevity increases. Basic salary does not include commissions, annuities, bonuses, overtime or incentive pay. For a teacher, basic salary does not include compensation for summer school.

Child — See *Dependent Child.*

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance coverage be offered to covered persons who lose health or dental coverage due to a qualifying event as defined in the Act. See also *Qualifying Event*.

Coinsurance — Coinsurance is the percentage of covered medical expenses a subscriber must pay in conjunction with the percentage paid by an insurance plan for covered expenses. These amounts are called coinsurance because both the subscriber and the insurance plan share the cost of health care expenses.

Coinsurance Maximum — The coinsurance maximum is the most money a subscriber would pay in coinsurance each year before an insurance plan begins to pay 100 percent of the allowable charge for covered expenses. This does not apply to the Medicare Supplemental plan.

Coordination of Benefits A system to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

Copayment A copayment is a fixed dollar amount of covered medical expenses a subscriber must pay in addition to what is paid by an insurance plan for covered expenses. These amounts are called copayments because both the subscriber and the insurance plan share the cost of health care expenses.

Copayment Maximum The most money in copayments a subscriber would pay each year before an insurance plan begins to pay the entire allowable charge for covered expenses.

Covered Dental Expense An expense that is provided for and deemed medically necessary by the plan up to the maximum amount listed in the *Schedule of Dental Procedures and Allowable Charges* (fee schedule) and is not excluded by any term, condition, limitation or exclusion of the Plan.

Covered Medical Expense A medical expense that is provided for by an insurance plan. A covered expense is a charge that is not excluded by any term, condition, limitation or exclusion of the plan.

Covered Person A person (employee, retiree, survivor, COBRA participant or dependent) who has met the eligibility requirements and is enrolled in an insurance plan. See also *Enrollee* and *Subscriber*.

Creditable Coverage Prior coverage under a group health plan or insurance coverage or health benefits provided as described or defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proof of creditable coverage (a form from your previous insurance company listing your dates of coverage) may be used to reduce a pre-existing condition limitation period, provided the prior coverage was continuous (provided any break in coverage did not exceed 62 days).

Deductible The amount a subscriber must pay each year if an annual deductible, or each encounter if a per occurrence deductible, toward covered expenses before the insurance plan begins paying benefits.

Deferred Effective Date A delayed effective date for insurance coverage, applicable to an employee who is absent from work due to injury or sickness on the date coverage would otherwise have become effective. The effective date is then deferred until the individual returns to work as an active, permanent, full-time employee for one full day.

Dental Course of Treatment All treatment performed in the oral cavity during one or more sessions as the result of the same diagnosis. Treatment includes examination, X-rays, prophylaxis and any complications arising from such treatment. Note: Some

surgical procedures may be covered by a subscriber's health plan.

Dental Deductible The amount of covered dental expenses you must pay before the plan will pay Class II and Class III combined benefits.

Dental Schedule of Procedures and Allowable Charges The list of dental procedures covered by the State Dental Plan and the allowable charges for each procedure established by the Plan Administrator for the payment of covered dental services.

Dentist A dentist or physician licensed in the jurisdiction where services are performed and practicing within the scope of his license.

Dependent Child An unmarried child under 19 years of age (or under age 25 if a full-time student) and who is principally dependent upon the subscriber for maintenance and support, provided the child is: (1) the natural or adopted child, stepchild, foster child or child for whom the subscriber has legal custody and who resides in the subscriber's home in a parent-child relationship; or (2) for whom the subscriber provides support and maintenance due to a court order. See also *"Full-time Student"* and *"Incapacitated Child."*

Dependent Spouse A lawful spouse of a subscriber, or former spouse required to be covered by a divorce decree or court order, but not both. If a spouse is also eligible for coverage or benefits as an employee of a state-covered entity, the spouse may not be covered as a dependent. However, a part-time teacher who is the spouse of a covered employee who is a state employee may be covered as either an employee or as a dependent, but not as both.

Employee An employee is a person employed by the state, a school district or a participating local subdivision who must be working at least 30 hours* a week in a position classified by the employer as permanent and full-time, and who receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision. This includes clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipality councils who participate in the South Carolina Retirement Systems (SCRS) also are considered employees for insurance purposes. If you work for two covered entities (dual employment), please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu$ and vision care program benefits. *Employers who participate in the Employee Insurance Program also have the option of reducing the threshold for insurance eligibility for permanent employees from 30 hours per week to at least 20 hours per week. This is at the option of the employer, and you should contact your benefits administrator for further information.

EIP The Employee Insurance Program.

Enrollee A person (employee, retiree, survivor, COBRA participant or dependent) who has met the eligibility requirements and is enrolled in an insurance plan. See also *Covered Person* and *Subscriber*.

Enrollment Date (1) The hire date for an employee; (2) the effective date of coverage for an individual who enrolls under a special eligibility situation and for a late entrant; and (3) the retirement date for a retiree.

Exclusion A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

Extended Care Benefits Benefits that provide for medical care in a more cost-effective setting when hospitalization is not required or necessary. Extended care benefits include home health care, skilled nursing facility care, hospice care and alternative treatment plans.

Funded Retiree Funded retirees are those retirees who are eligible for the employer contribution to their retiree insurance premiums

Full-time Student An unmarried child who is 19 years of age but less than 25 years of age who is enrolled in and attending a high school, trade, vocational or technical school or college (not correspondence courses) on a full-time basis as defined by the institution.

Health Maintenance Organization (HMO) A managed care plan that has contractual arrangements with healthcare providers (doctors, hospitals, etc.) who together form a provider network. HMO subscribers are required to see only providers within this network. If a subscriber receives care outside of this network, the HMO will not pay benefits for these services unless the care was pre-authorized or deemed an emergency. Subscribers choose a primary care physician (PCP) who coordinates all aspects of the subscriber's healthcare. To receive benefits, subscribers must receive a referral from their PCP before they can see a specialist.

Home Health Care Part-time nursing care; health aide service; or physical, occupational or speech therapy provided by an approved home health care agency and given in the subscriber's home. These services do not include custodial care or care given by a person who ordinarily lives in the home or a member of the subscriber's family or the spouse's family.

Hospital A legally designated and operated institution caring for the sick, such as a general hospital; children's hospital; eye, ear, nose and throat hospital; maternity hospital or an ambulatory surgical center. "Hospital" also includes a legally constituted and operational psychiatric facility for the treatment of mental or nervous conditions or substance abuse. Hospitals must provide inpatient care given by, or supervised by, a staff of licensed physicians and must provide

continuous 24-hour services by licensed registered nurses who are physically present and on duty. Nursing homes, rest homes, homes for the aged and convalescent homes are typically not considered hospitals under insurance plans, whether or not they are affiliated with a hospital.

Incapacitated Child An unmarried child who is incapable of self-sustaining employment because of mental illness or physical handicap and is principally dependent on the subscriber for maintenance and support. Incapacitation must have begun before age 19 or while an eligible covered dependent, full-time student. If eligible but not previously covered, the child may not be added until the next open enrollment period (or within 31 days of a special eligibility situation), and coverage is subject to pre-existing condition limitations.

Incurred Expense An expense is considered incurred on the date services were rendered or supplies were received.

Identification Number For most plans, typically the covered person's Social Security number. Identification cards are issued by the insurance plan. Note for retirees: Under the State Health Plan Economy, Standard or Medicare Supplemental plan, the retiree's Social Security number is used for all covered family members. Use the number listed on the Medicare card for Medicare claims and information. Note for survivors: For surviving spouses and surviving spouses with covered children, the surviving spouse's Social Security number is used for all covered family members. For surviving children only, the youngest child's Social Security number is used.

Injury An accidental bodily injury that requires treatment by a physician. Any loss that results from the injury must be independent of sickness or other causes.

Late Entrant A full-time employee or eligible retiree, and any eligible dependent of that employee or retiree, who is not enrolled within 31 days of that person's first date of eligibility and who subsequently enrolls during an open enrollment period. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage begins.

Local Subdivision Any participating entity covered by local jurisdiction rather than state. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. To be eligible to participate in the state insurance benefits program, a public entity in South Carolina must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

Medi-Call

Medi-Call is the patient utilization review program for State Health Plan subscribers. Medi-Call ensures subscribers receive appropriate medical care in the most beneficial, cost-effective manner. Note: Retirees and dependents entitled to Medicare must call Medi-Call for home health care, hospice, durable medical equipment, Veterans Administration hospital services and when the number of hospital days allowed by Medicare is exceeded.

Medically Necessary

Services or supplies ordered by a physician or behavioral health care provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient receives the service and in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Medicare Supplemental Plan

A health plan offered to retirees and their dependents that are entitled to Medicare. As a "supplemental" plan, it generally pays the deductibles and coinsurance amounts for Medicare approved services that Medicare does not.

Mental Health And Substance Abuse Provider

A physician, psychiatrist, health professional or any other entity or institutional health care provider under agreement to participate in a behavioral health provider network administered by the Mental Health and Substance Abuse Manager.

National Committee For Quality Assurance (NCQA)

A private, not-for-profit organization that is dedicated to improving health care quality. NCQA is active in quality oversight and improvement initiatives at all levels of the health care system—from evaluation entire systems of care to recognizing individual providers that demonstrate excellence. NCQA is best known for its work in assessing and reporting on the quality of the nation's managed care plans through their accreditation and performance measurement programs.

Non-funded Retirees

Non-funded retirees are those retirees that do not qualify for funded benefits and who must pay the full premium cost (includes retiree share plus employer contribution) for their insurance.

Non-Preferred Brand Drug

Medications that do not appear on the Preferred Brand list and that carry a higher copayment. All medications that appear on the non-preferred brand list have an effective alternate option either as a generic or preferred brand drug.

Notice of Election Form

The Notice of Election (NOE) form is the application form used to enroll in benefits; add or delete dependents; or change coverage level, beneficiary, name or address.

Open Enrollment

A period during which eligible employees, retirees, survivors and COBRA

subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan without regard to any special eligibility situations. Retirees may also change to and from the Medicare Supplemental program during an open enrollment period. An open enrollment period is held every other year in October. Enrollment changes become effective the following January 1.

Out-Of-Network Differential If you choose to go to a health care provider that does not participate in a State Health Plan network, you will be responsible for a higher coinsurance percentage of your covered medical expenses and you may be balance-billed the difference between the allowed and actual charge. This out-of-network differential applies to all State Health Plan networks except the Mental Health and Substance Abuse and Pharmacy networks where no out-of-network benefits are provided.

Out-Of-Pocket Maximum The most money a covered person will be required to pay a year in deductibles, copayments and coinsurance. The amount is set by each insurance plan.

Part-Time Teachers Teachers who are in a permanent position and work at least 15 hours but no more than 29 hours per week at a South Carolina public school, the South Carolina Department of Juvenile Justice or the South Carolina Department of Corrections are eligible for state health, dental MoneyPlu$ and vision care program benefits. They must also be in a contract position and receive an Education Improvement Act (EIA) salary supplement. Premiums are determined by the number of hours an eligible part-time teacher works per week.

"Pay-the-Difference" Policy If a generic drug is available and a subscriber chooses to purchase or his doctor prescribes the brand name medication instead, the benefit will be limited to the amount payable for the generic medication. The subscriber will be responsible for the difference in benefit between the brand name drug and the generic drug plus the generic copayment amount. The difference does not apply to annual copayment maximum.

Per-Occurrence Deductible The amount a covered person must pay each time there's an emergency room, inpatient or outpatient hospital service before the health plan begins to pay benefits.

Per Visit Deductible The amount a covered person must pay each time they have a physician office visit before the health plan begins to pay benefits.

Physician A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, psychiatrist or licensed counseling or clinical psychologist.

Plan The State Health Plan or the State Dental Plan.

Plan Year January 1 through December 31 (calendar year).

Point of Service (POS) A managed care plan that allows subscribers to choose to use providers or specialists within the plan's network as referred by their primary care physician, or subscribers can self-refer to a provider outside the network. Subscribers may use out-of-network services, however benefits are paid at a reduced level.

Pre-Existing Condition Any medical condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed health care provider or practitioner in the six months preceding the covered person's enrollment date. Benefits for a pre-existing condition are payable only for treatment provided at least 12 months (18 months for a late entrant) after enrollment. Pregnancy does not constitute a pre-existing condition. See also *Creditable Coverage.*

Preferred Brand Drugs Medications that have been determined safe, effective and available at a lower cost by Medco's Pharmacy and Therapeutics Committee. A list of preferred brand medications is available at www.medcohealth.com.

Preferred Provider Organization A PPO is a type of health or dental plan that is similar to a fee-for-service plan. A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you.

Premium The amount a covered person pays in exchange for insurance coverage.

Prescription Drug Any drug or medicine required to bear the following wording, "Caution: Federal law prohibits dispensing without prescription." Insulin or drugs licensed or accepted for a specific diagnosis as listed in the U.S. Pharmacopoedia Publication, *Drug Information for Health Care Professionals*, are also considered prescription drugs. Drugs in FDA phase I, II or III testing are not covered.

Primary Care Physician/Doctor Usually the first contact for health care, this is often a family physician, internist, pediatrician, or in some cases, a gynecologist. A primary care physician monitors the patient's health and diagnoses and treats minor health problems and refers the patient to specialists if another level of care is necessary.

Private Duty Nursing Services Private services of a registered nurse or licensed practical nurse. Services must be certified in writing by a physician as medically necessary.

Provider Any person (i.e., doctor, nurse, dentist) or facility (i.e., hospital or clinic) that provides medical care.

Qualifying Event	An event that allows insurance coverage or an extension of insurance coverage for an employee, spouse or dependent. Such events may be marriage, birth/adoption/placement, loss of group health plan coverage, divorce/legal separation, death of the covered employee, loss of dependent's eligibility for coverage, etc.
Self-Funded Plan	A self-funded insurance plan is one in which the employer or group of employers assume direct financial responsibility for the costs of enrollees health claims. Employers sponsoring self-funded plans typically contract with an insurance carrier or third party administrator to provide administrative services for the self-funded plan.
SHP	See *State Health Plan.*
Sickness	A disease, disorder or condition that requires treatment by a physician.
Significant Break in Coverage	A period of 63 or more consecutive days during which an individual does not have any creditable insurance coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. See also *Creditable Coverage.*
Skilled Care	Services provided according to a physician's order, given by or under the direction of a qualified technical or professional health care provider. Health care providers include registered nurses, licensed practical nurses, physical therapists, speech pathologists and audiologists.
Special Eligibility Situation	A qualifying event that allows eligible employees, retirees, survivors or COBRA subscribers to enroll themselves and/or their eligible dependents in an insurance plan. Examples include: marriage, birth, adoption or placement. Involuntary loss of other coverage applies only to those who lost coverage. Enrollment changes must be requested within 31 days of the qualifying event. Note: A salary increase does not constitute a special eligibility situation. See also *Qualifying Event*.
Spouse	See *Dependent Spouse*.
State-Covered Entity	A state agency, public school district, county, municipality or other group participating in the Plan.
State Health Plan (SHP)	The term used generally to identify the Economy, Standard, and Medicare Supplemental plans.
Subscriber	All active and retired employees, survivors and COBRA continuees of state agencies, public school districts, participating counties and other eligible entities, and their dependents who are enrolled in a benefits plan. See also *Covered Person* and *Enrollee*.

TERI Teacher and Employee Retention Incentive program of the South Carolina Retirement Systems.

Transfer/ Transferring Employee An active employee who changes employment from one state group entity to another with no more than a 15-calendar-day break in employment or in insurance coverage. An academic employee who completes a school term and moves to another academic setting at the beginning of the next school term is also considered a transferring employee. A transferring employee is not considered a new hire for insurance program purposes.

You Any person who is insured under the policy. You and/or your covered dependents.

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